STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 91401-001**

v

American Community Mutual Insurance Company
Respondent
_____/

Issued and entered
this 18th day of September 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On August 5, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of the Office of Financial and Insurance Regulation under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq.* The Commissioner reviewed the request and accepted it on August 17, 2008.

The Commissioner notified American Community Mutual Insurance Company (ACMIC) of the external review and requested the information used in making its adverse determination. The Commissioner received the initial information from the company on August 18 and 20, 2008.

The Petitioner has individual coverage with ACMIC. The issue here can be decided by an analysis of the Petitioner's policy. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On March 23, 2007, the Petitioner had a comprehensive eye examination that determined she had cortical cataracts in both eyes. On June 1, 2007, the Petitioner's health care coverage with ACMIC became effective.

The Petitioner received treatment for cataracts and related services on December 6 and December 20, 2007. ACMIC denied coverage for services saying they were treatment for a pre-existing condition. The Petitioner appealed.

ACMIC reviewed the claim but upheld the denial. The Petitioner completed ACMIC's internal grievance process and received a final adverse determination dated July 18, 2008.

III
ISSUE

Was ACMIC correct in denying coverage for the December 6 and December 20, 2007 services as exclusions for a pre-existing condition?

IV
ANALYSIS

Petitioner's Argument

On March 23, 2007, the Petitioner had a comprehensive eye examination that showed that her best corrected visual acuity was 20/40 in her right eye and 20/30 in her left eye. There was also intraocular lens clouding that was determined to be a cortical cataract in each eye. The intraocular clouding was in addition to anterior subcapsular clouding that had been present for many years. The cataracts were now causing problems with her vision to the point that she could not function in her daily living. Her doctor recommended cataract surgery.

The Petitioner does not understand why the blurred vision and clouding that had been present all her life should be considered as a disorder or a pre-existing condition.

American Community Mutual Insurance Company's Argument

The Petitioner's policy with ACMIC became effective on June 1, 2007. The policy does not cover pre-existing conditions. "Pre-existing condition" is defined in the policy as:

> a Sickness or Injury for which medical advice, diagnosis, care or Treatment was recommended or received within 6 months before the Effective Date. A Sickness that appeared or an Injury sustained prior to the Effective Date of the Family Member's coverage, was fully disclosed on the application, and was not excluded from coverage by a rider is not a Pre-existing Condition. [Underling added]

Under "General Exclusions," the policy says (page 23):

> 1. Pre-existing Conditions. We do not pay for any expenses incurred due to any Pre-existing Condition during the 12-month period beginning on the Family Member's Effective Date.

ACMIC points out that the Petitioner was diagnosed with cataracts on March 23, 2007, and had a history of blurred vision symptoms dating back years. By March 2007, the cloudiness had gotten so bad that it was affecting her daily living and now surgical intervention was medically necessary. ACMIC says the Petitioner did not disclose that she had eye disorders in her application completed April 5, 2007.

ACMIC says it could have rescinded the policy but determined, since the condition had been surgically treated, it would offer the Petitioner continued coverage subject to a one-year exclusion rider for the treatment of cataracts and a 25% increase in premium.

Because the Petitioner first experienced symptoms of cloudiness and blurred vision prior to her effective date of June 1, 2007, ACMIC asserts that she met the definition of pre-existing condition and that its denial of benefits for the cataract surgery was correct.

Commissioner's Review

The Commissioner has carefully reviewed the arguments of parties as well as the documentation and certificate of coverage.

The Petitioner says that she has experienced blurred vision and cloudiness since birth and therefore she did not consider it a disorder; that is why she did not respond "yes" to the question on

the application that asked if she had any eye disorders. However, on March 23, 2007, Gary Anderson, OD, diagnosed her with cataracts and increased cloudiness and recommended surgery. The Commissioner finds the Petitioner had a pre-existing condition because she received "diagnosis, care or treatment" for the cataracts within six months before the effective date of her coverage. Since expenses incurred due to pre-existing conditions are not paid during the 12 months beginning on the effective date of the policy (or until June 1, 2008, in the Petitioner's case), ACMIC correctly denied coverage for the cataract surgery performed on December 6 and December 20, 2007, according to the terms and conditions of the policy.

V
ORDER

The Commissioner upholds the adverse determination by American Community Mutual Insurance Company on July 18, 2008. ACMIC is not required to pay for the pre-existing conditions.

This is a final decision of an administrative agency. Under MCL 550.1915, any person aggrieved by this Order may seek judicial review no later than sixty days from the date of this Order in the circuit court for the county where the covered person resides or in the circuit court of Ingham County. A copy of the petition for judicial review should be sent to the Commissioner of the Office of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.